STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003767	A. BUILDING _____ B. WING _____	06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HOSPITAL OF NORTHWEST INDIANA	4321 FIR ST 4TH FL EAST CHICAGO, IN 46312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a standard licensure survey. Facility Number: 003767 Survey Date: 06/01-02/2011 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Regency Hospital of Northwest Indiana is in compliance with 410 IAC 15.1, Hospital licensure Rules. QA: claughlin 06/10/11	S 000		